Compassionate Care Program
Financial Assistance Program Guidelines

Purpose:

The Florida Hemophilia Association's (FHA) Compassionate Care financial assistance program is part of FHA's continuing effort to improve the quality of life of individuals and families affected by bleeding disorders. This program provides funds to eligible individuals and families who need assistance with:

- Expenses incurred in the care, treatment, or prevention of a bleeding disorder, and/or
- Basic living expense emergencies.

Note: This program is intended to help individuals and families who have exhausted all other sources of assistance and for whom no other funds are available.

Eligibility:

To be eligible for this program you must meet the following criteria:

- You must be a resident of Florida AND provide a letter from your treatment center, hematologist or provider verifying that you receive treatment for a bleeding disorder.
- You must be the parent or caregiver of a minor child who lives in your home and who has a diagnosis of a bleeding disorder; OR be an individual with a diagnosis of a bleeding disorder.
- You must complete all sections of the application thoroughly and accurately.

Administration:

- Financial assistance depends on the availability of funds and applicant eligibility. Funding is not guaranteed. Applicants should allow at least two weeks for FHA to process their request.
- Assistance is limited to one grant per calendar year and a maximum of $500. In the presence of special circumstances, the FHA Board of Directors will review exceptional requests.
- Disbursements will be made only to creditors identified in the application and that have been verified by FHA. No payments will be made directly to applicants with the exceptions of gift card for groceries and or other approved items.

Request Process:

1. Requestor must provide the following:
    a. Formal letter of need, including an explanation of the situation and all contact information
    b. Letter from treatment center, hematologist or provider verifying treatment for a bleeding disorder
    c. Copy of bill or invoice for which payment is requested

2. Completed applications must be submitted by email dadamkin@floridahemophilia.org or fax (954) 900-5149
3. The FHA staff will review applications for completeness and consider the date the funds are needed in order to determine the urgency of the request.
4. Incomplete applications will be returned to the applicant with an explanation of why it was returned and a description of the information still required.

5. Complete applications will be sent to the FHA committee for review.
6. If the application is approved, FHA staff will notify the applicant, and a check will be mailed to the creditor identified on the application
7. If the application is rejected, FHA staff will notify the applicant with an explanation.

Confidentiality:

- Applications and information pertaining to funding requests are considered confidential.
- Information from FHA Compassionate Care financial assistance program applications may be compiled for statistical purposes, and for compliance with local, state, federal or affiliate organization requirements. However, any publication of this data will be in aggregate form only, and will not include names or any other information that could be used to identify individual applicants or recipients.
- No personal information will be used or disclosed for any purpose other than that for which it was collected. At no time will personal information be shared with any individual, company or organization outside of the Florida Hemophilia Association

Compete the application below:

Patient Assistance Program Application

Applicant's Name:____

Bleeding Disorder *(provide diagnosis and severity):*____

Street Address: ____

City: _____________________________________ State: ______________ Zip Code: _________________

Phone Number:_______________________________ Email Address: _______________________________

Assistance needed for:______________________________________ Date due:______________________

Description of circumstances surrounding request and how funds will be used:__________________________

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Amount requested:____

Check payable to:____

Address/City/ST/Zip:____

Contact Name:____

Phone number:____

Please include the following supporting documents

- Letter from HTC Nurse, Social Worker or Other Provider that describes the circumstances surrounding the request
- Copy of Invoice that assistance is being requested for
    - For rent assistance, please attach a copy of the lease

Please send completed application and supporting documents to FHA

Email: info@floridahemophilia.org Fax: (954) 900-5149

Date received in office:__________________ Amount Approved:_____________________________

Approved by:____

Date check sent:_______________________ Check Number:________________________________